EYE CARE & EYE WEAR CENTER of MAINE

Douglas Gauvreau, OD   Eric Roush, OD   Jennifer Haverkamp, OD

PATIENT DEMOGRAPHIC FORM

PLEASE FILL-IN ALL INFORMATION
(This information is required by new federal regulations)

(circle one): Mr. Mrs. Ms. Master Dr. Prof. Rev. Sister

NAME:____SUFFIX:__________SEX: M / F

DOB:___________________AGE:___________BIRTH STATE:______________________________

SSN (patient's social security number):____

MOTHER'S MAIDEN NAME____

PRIMARY LANGUAGE:______________________________

RACE: (circle one): American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Other Race:_____________________________

ETHNICITY (circle one): Hispanic or Latino, not Hispanic or Latino, Unknown

ADDRESS:

STREET:____

CITY:____STATE:_______________ZIP:_____________

COMMUNICATION:

PREFERENCE (call home, work, cell, e-mail), etc.):____

HOME PHONE:______________________________

WORK PHONE:______________________________

CELL PHONE:___________________________ CARRIER (AT&T, Verizon, etc.):________________

E-MAIL:____________________________________

Who is your primary care doctor?___________________________________ Town:______________

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INSURANCE BILLING SIGNATURE FORM

PLEASE READ & SIGN

Your insurance company may not pay for all your COVERED services. A “covered service” may require that you pay your deductible and/or co-pay and co-insurance. In the event that your insurance company does not pay all or part of your claim, you agree to pay for services rendered.

If the doctor determines that your eye problem is due to a medical condition, including annual diabetic examinations, we will bill your medical insurance for your office visit. Most VSP & EyeMed Vision Insurance cover routine vision care, not medical eye care.

Your signature below authorizes Eye Care & Eye Wear Center of Maine to bill your insurance company on your behalf. It also serves to authorize any information be provided that your insurance company may require to process your claim.

I am familiar with the Eye Care & Eye Wear Center of Maine Notice of Privacy Practices.

NAME of INSURANCE PLAN:____

MAME of VISION PLAN:____

PATIENT NAME:_____________________________________ DATE of BIRTH:__________________

POLICYHOLDER:_____________________________________ DATE of BIRTH:_________________

POLICYHOLDER PLACE of EMPLOYMENT:____

____ ________________________

SIGNATURE DATE

RESPONSIBLE for PAYMENT (if patient is a minor):_______________________________________

SOCIAL SECURITY NUMBER:______________________________________

____ ________________________

SIGNATURE DATE

NAME:________________________________DOB:__________ACCT:____________

1. Please complete all information. This will help the doctor in evaluating and treating your eye condition. This form is required for insurance billing.

PLEASE CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight - sudden gain
- ☐ Weight - sudden loss

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

EAR, NOSE, THROAT
- ☐ Dizziness
- ☐ Hearing Loss

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema

GASTROINTESTINAL
- ☐ Diverticulitis
- ☐ Hepatitis A / B / C

GENITOURINARY
- ☐ Frequent Urination
- ☐ Prostate Cancer

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Sjogrens Syndrome
- ☐ Systemic Lupus

PSYCHIATRIC
- ☐ Depression

INTEGUMENTARY
- ☐ Skin Cancer
- ☐ Skin Rash

NEUROLOGICAL
- ☐ Migraines
- ☐ Paralysis
- ☐ Stroke

ENDOCRINE
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

HEMATOLOGIC
- ☐ Anemia
- ☐ Leukemia

IMMUNOLOGIC
- ☐ HIV / AIDS
- ☐ Autoimmune Disorder

____

EYE HISTORY

Do you have
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Lazy Eye (Amblyopia)
- ☐ Dry Eye
- ☐ Eye Surgery

FAMILY HISTORY (Parents / Grandparents / Brothers / Sisters)

Does anyone in your family have any of the following? Who?
- ☐ Glaucoma________________________________
- ☐ Macular Degeneration (ARMD)________________________________
- ☐ Blindness________________________________
- ☐ Lazy Eye (Amblyopia)________________________________
- ☐ Diabetes________________________________
- ☐ Eye Surgery________________________________

MEDICATIONS: ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

ALLERGIES TO MEDICATIONS:____

ENVIRONMENTAL ALLERGIES:____

Are you interested in contact lenses?__________Do you currently wear contact lenses?____________

Do you smoke?
- ☐ Smoker
- ☐ Former smoker
- ☐ Never a smoker

Please read:

Eye Care & Eye Wear Center of Maine recommends that you do not smoke.
Smoking can contribute to macular degeneration and cataracts.